



ND RYAN WHITE PROGRAM PART B REENROLLMENT APPLICATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 58583 (01-2015)

The following information is requested to determine if you continue to qualify for North Dakota Ryan White Program Part B. The law does not require that you provide the information. However, without this information we may be unable to determine your eligibility for assistance or help you with appropriate referrals.

It is against the law for you to provide information that is not true. If you do, you may be charged with a crime.

All the information you provide is private and confidential. Only those people who need the information to do their jobs will see your information. These people are the North Dakota Ryan White Program Part B staff, program auditors, private health insurance plans, your medical care providers, the county financial worker, your case manager, and any advocate you may list on this application. We will ask your permission for anyone else to see the information you give us.

Items you will need to provide:

- **Income:** Bring records to show your gross income (wage stubs, SSDI, SSI, tax forms, etc.).
- **Health insurance:** Bring explanation of any change in benefits since initial enrollment period.
- **Residence:** Bring records to show where you live (rent receipts, utility bills, etc.).
- **Program Verification:** You may be asked to provide acceptance or denial letters from other programs that you have been asked to apply for such as Medicaid and Medicare.

When you fill out this application:

- Answer all questions completely.
- Review the form to make sure you have answered all the questions you can.
- Sign and date where indicated.
- Return this form to your case manager.

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ND Ryan White Case Management Site	ND Ryan White Client Number
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Applicant

Name		
Home Telephone Number	Cell Phone Number	Email Address
Home Address		
City	State	Zip Code
Mailing Address (if different than home address)		
City	State	Zip Code
Employer's Name		

Physician

Name	Telephone Number	
Clinic's Name		
Clinic's Address		
City	State	Zip Code

Pharmacy

Name	Telephone Number	
Address		
City	State	Zip Code

Emergency Contact

Name		
Home Telephone Number	Cell Phone Number	Email Address

Assistance Requested

- | | |
|---|--|
| <input type="checkbox"/> Case management (all clients eligible) | <input type="checkbox"/> Drug assistance program (ND Ryan White Program Part B Drug Formulary) |
| <input type="checkbox"/> Health care (medical, oral) payment assistance | <input type="checkbox"/> No change in assistance needed |
| <input type="checkbox"/> Supportive services (transportation, housing) | |
| <input type="checkbox"/> Other | |

Health Care Coverage

- ☐ Medicaid (Traditional) _____
- ☐ Medicaid Expansion _____
- ☐ Private - Individual _____
- Is this a Marketplace plan? ☐ Yes ☐ No
- ☐ Private - Employer _____
- ☐ Medicare D _____

Has your insurance coverage changed since last enrollment?

- ☐ Yes, documentation provided ☐ No

Tobacco

1. Are you a tobacco user? ☐ Yes ☐ No ☐ Former User
2. Are you interested in quitting at this time? ☐ Yes ☐ No
3. Are you exposed to second hand smoke? ☐ Yes ☐ No
4. Referral offered? ☐ Yes ☐ No

Household Characteristics

Household/family size: _____

Has your living situation changed since last enrollment?

- ☐ Yes ☐ No If Yes, please explain: _____

Household Income

What is your yearly gross household income? _____

Please include W2s or one month of pay stubs with this application for all household members 18 years of age and older related to you by blood, marriage or adoption. If you are unemployed and/or did not file for taxes please sign the income verification form.

Certification

I hereby certify that the representation of my income, insurance and other financial assistance is a true and accurate statement and that eligibility requirements as listed above have been met and documented. I also certify that any increases in income, insurance or other financial assistance will immediately be reported to my case manager. I understand reenrollment on an annual basis is required. I understand I must complete the reenrollment application annually, and **if I have not reenrolled by May 31 and recertified by November 31, I will become ineligible to receive services through the ND Ryan White Program Part B.** I have received a copy of my responsibilities as a ND Ryan White Program Part B client and I agree to all terms. ☐ Yes ☐ No

Client Signature

Date

Case Manager's Signature

Date